Research Highlights

From the Survey and Evaluation Research Laboratory
at Virginia Commonwealth University's Center for Public Policy

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Research conducted for the Virginia HIV Community Planning Committee

African-American Clergy See Need for and Obstacles to HIV Prevention Programming

African-American clergy in Virginia are aware that HIV/AIDS has disproportionately affected African Americans, and believe that religious institutions should be involved in the response to the epidemic. Yet they acknowledge that many African-American churches and mosques have been slow to respond. Barriers include discomfort in dealing with sexual issues in religious settings, antipathy towards homosexuality and other lifestyles associated with HIV/AIDS, and denial that HIV/AIDS is of special concern to African Americans.

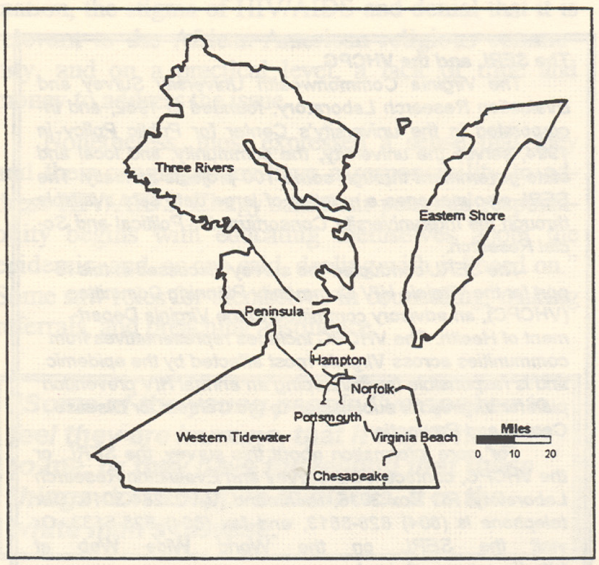
These are some of the views expressed by African-American clergy and lay leaders in focus groups and interviews conducted September 1997-May 1998 by Virginia Commonwealth University's Survey and Evaluation Research Laboratory (SERL) on behalf of the Virginia HIV Community Planning Committee (VHCPC). With this study, the VHCPC sought to assess the readiness of African-American congregations to respond to HIV prevention needs among their members and others living in the neighborhoods they serve. The study was conducted in the Eastern Virginia Health Region, which encompasses a variety of settings, from Norfolk, with its high density of people living with HIV and AIDS, to rural areas such as the Eastern Shore, where relatively few people are HIV-positive.

Background and Method

This study is one component of the VHCPC's African-American Faith Initiative (AAFI), which aims to promote prevention programming in Virginia's African-American religious institutions. The AAFI grew out of an earlier effort to survey clergy across Virginia from all racial and ethnic groups. While that survey yielded an adequate response from white clergy, it was not successful in recruiting respondents from African-American denominations. When a second intensive effort to encourage African-American clergy to complete the survey also failed, the VHCPC formed a Black Clergy Advisory Committee to develop a new strategy for gathering information from African-American religious communities.

The VHCPC's persistence was founded on an appreciation of the centrality of organized religion in the lives of many African Americans, and on the traditions of social activism in African-American churches and mosques. As compared to others involved in HIV prevention, such as government agencies or health care providers, many churches enjoy an edge in access, credibility, and persuasive power in African-American communities. However, the church's potential to bring the HIV prevention mes-

Figure 1. The Eastern Virginia Health Region.



sage home to African Americans has not been fully realized. With a few exceptions, African-American churches and mosques have not taken a leading role in responding to AIDS as they have done on other social issues.

Educating African Americans about HIV/AIDS and stimulating behavior change are particularly important because of the high and growing proportion of Virginians with HIV/AIDS who are African American. In 1997, when African Americans made up 33 percent of the population of the Eastern Region, they represented 70 percent of HIV cases and 60 percent of AIDS cases reported. By the end of 1997, some 3,000 African Americans were known to be living with HIV or AIDS in the Eastern Region. Figures 2 shows a breakdown by race and gender of people living with HIV and AIDS in the region.

The Black Clergy Advisory Committee recommended a two-part study. First, churches with HIV ministries would host focus groups to which they would invite representatives from churches without HIV programs from the same or similar denominations. In the second part of the study, clergy who had not participated in focus groups would be interviewed individually. Focus groups were held in the fall of 1997, and were facilitated by an African-American pastor with a Doctor of Divinity Degree. Interviews took place the following spring and were conducted by trained interviewers.

All focus groups and interviews took place in the Eastern Virginia Health Region. Eastern Virginia was selected from among the state's health regions because it has highest rates of HIV and AIDS infection among African Americans, and because it already had an infrastructure for the study, created during the earlier effort to distribute surveys.

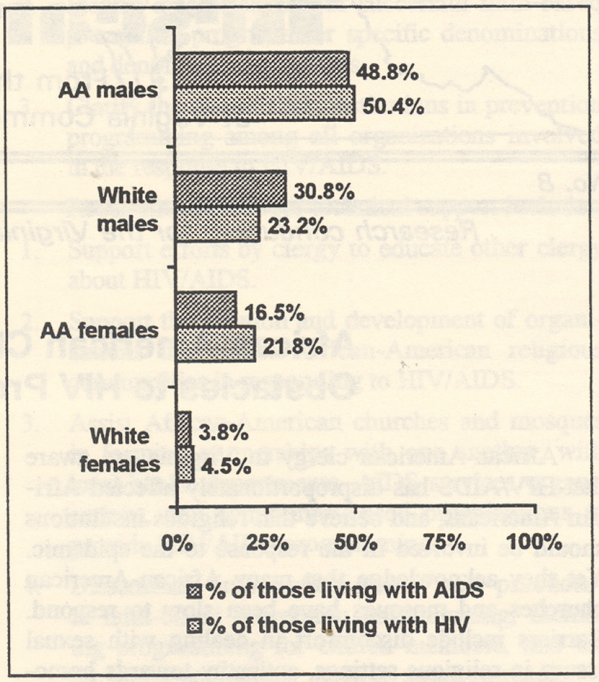
The SERL and the VHCPC

The Virginia Commonwealth University Survey and Evaluation Research Laboratory, founded in 1982, and incorporated in the university's Center for Public Policy in 1994, serves the university, the community, and local and state government through some 100 projects annually. The SERL also manages a number of large data sets available through the Interuniversity Consortium for Political and Social Research.

The SERL conducted the survey discussed in this report for the Virginia HIV Community Planning Committee (VHCPC), an advisory committee to the Virginia Department of Health. The VHCPC includes representatives from communities across Virginia most affected by the epidemic and is responsible for developing an annual HIV prevention plan for Virginia for submission to the Centers for Disease Control and Prevention.

For more information about this survey, the SERL, or the VHCPC, contact: VCU Survey and Evaluation Research Laboratory, PO Box 3016, Richmond, VA 23284-3016. Our telephone is (804) 828-8813, and fax (804) 828-6133. Or visit the SERL on the World Wide Web at http://www.vcu.edu/serl

Figure 2. Persons living with HIV and AIDS by race and gender as a percentage of all cases in Eastern Virginia, as of December 31, 1997.



Focus group and interview participants included clergy and lay leaders, represented several different denominations, and came from both urban and rural areas. A breakdown of participants by denomination is presented in Table 1.

Participants were asked about the spread of HIV among African Americans; about attitudes towards and ease in talking with congregations about sex, homosexuality, and drug use; and about church and clergy roles in the HIV epidemic and the nature and adequacy of the church's response. A summary of responses to these questions is presented here. While focus groups and interviews do not allow the researcher to assess precisely how common a given view may be, they do provide a means to explore a range of views, and hear about issues as participants choose to tell them.

Results

HIV/AIDS among African Americans. Study participants were aware of the prevalence of HIV/AIDS among African Americans. Some knew of people with HIV or AIDS in their own congregations, or acknowledged that the epidemic had affected the communities they serve.

They offered several explanations for the disproportionate impact on African Americans. Many cited a lack of knowledge, both knowledge about HIV/AIDS, and about religious values and norms

Table 1. Denomination of focus group participants and individuals interviewed

Focus Groups	
Fundamentalist: N=3 groups (64 individuals)	♦ Faith Deliverance Christian Center ♦ Operation Breaking Through ♦ Church of God in Christ
Catholic: N=1 group (9 individuals)	♦ Catholic
Mainstream Protestant: N=1 group (45 individuals)	♦ Baptist
Islam: N=1 group (10 individuals)	♦ Al Quba
Personal Interviews	
Fundamentalist: N=3	♦ Pentecostal
Catholic: N=4	♦ Catholic
Mainstream Protestant: N=14	♦ African Methodist Episcopal ♦ Christian Methodist Episcopal ♦ Baptist
Islam: N=1	♦ Islamic Masjid

they believe help protect against HIV transmission. Some said that economic conditions and unemployment make African Americans vulnerable to risky lifestyles, particularly in poor neighborhoods. Some pointed to a general moral decline and deterioration of family structures. Several of those interviewed mentioned denial as a problem—particularly denial that HIV affects African Americans. One clergy person said, "Some of the young people I've spoken to feel they are immune, that it won't happen to me, or they have the feeling that these things don't happen to blacks. It is the white man's disease."

Dealing with sex, homosexuality, and drug use. Several participants acknowledged personal discomfort discussing sexual issues in a church setting, or said their congregations are reluctant to talk or hear about sex in church. As one clergy person interviewed said, "I think we may be uncomfortable with the issues that surround the disease, and to preach about it from the pulpit, we find it uncomfortable."

The problem is complicated by the association of HIV/AIDS with homosexuality, sex with multiple partners, and intravenous drug use, behaviors the clergy interviewed perceive as sinful. Some said they felt they were in a bind, uncertain how to deliver prevention messages without seeming to condone sinful behavior. One said the congregation responds to any talk about sex, "They will say you are promoting sex..."

For many the answer to this dilemma is preaching abstinence. One said, "We need to preach abstinence because that is what we're mandated to do. Sexual encounters outside of the marital bond are simply wrong." Another said, "We preach almost on a daily basis to the young that they should abstain from sex."

While many participants expressed strong conviction that homosexual behavior and sex outside of marriage are sinful, they also felt it was unacceptable to turn away from people with HIV, or people whose lifestyles put them at particular risk for HIV. Some said it was important that the church provide spiritual guidance to encourage behavior change. One clergy person said, "These persons that have these types of lifestyles, they are involved in that type of sin because they don't know the way, they don't know the truth. The church must not turn away from them, but they must show them the better way in Jesus Christ."

Religious response to HIV/AIDS. Several participants said African-American religious institutions had been slow to respond to HIV/AIDS, and cited several obstacles to HIV prevention programming in churches or mosques. First is discomfort in dealing with the relevant sexual issues, and the dilemma of providing useful information without seeming to tolerate behavior the church deems sinful. One participant said, "The church finds itself struggling with ways to actually get out to really address this matter... It's a subject matter that people aren't willing to talk about." Participants also cited a lack of information, the stigma of HIV/AIDS and denial that it is relevant to the African-American religious community, and on a practical level, a lack of time and money to address the issue.

Nonetheless, most expressed a sense that they and their congregations have a responsibility to address HIV/AIDS. Clergy said their personal responsibility begins with educating themselves about the epidemic, and, as one said, dealing with it "head on." Some saw roles for themselves in counseling, making referrals, and preaching abstinence.

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The congregations represented were responding to the epidemic in different ways, and with different levels of intensity. Most were in early stages, addressing the issues occasionally and informally. Some had made HIV resources available to members, held workshops, or sponsored AIDS awareness Sundays. A few had AIDS ministries that had been in operation for several years. Whatever the level of congregational response, many of those interviewed emphasized the importance of a response that originates with the African-American church and the communities it supports.

At the end of the study, the organizations that had hosted focus groups were asked whether their participation had influenced their ministries. Four of the six replied, citing recent activities. The Faith Deliverance Christian Center had extended outreach to rural areas, and had hosted a health fair at which more than 400 people had been tested for the HIV antibody. The New Hope Church of Christ had also hosted a health fair and initiated a weekly radio show providing inspirational messages to those affected by HIV. Operation Breaking Through, which received a grant from the Virginia Department of Health to provide abstinence-based prevention programming to teens, said that participation in the study reinforced their commitment to HIV/AIDS education in the 45 churches in their coalition. The Basilica of St. Mary's of the Immaculate Conception hosted an HIV/AIDS workshop for the community, and began to train the Church Parish Council in ministering to people with HIV/AIDS.

Recommendations

Study findings suggest that representatives of African-American religious institutions in Virginia are interested in increasing their involvement in HIV/AIDS prevention. At the same time, they are aware of obstacles to involvement, and express some uncertainty about how to confront the issue.

The VHCPC recommends additional research and technical support to help clergy and congregations respond to the epidemic in ways that are both effective and consistent with their ethics and religious teachings.

Recommendations for research include:

1. Identify barriers to prevention programming in African-American religious institutions, and ways in which churches and mosques have overcome those barriers.
2. Identify characteristics of successful faith-based prevention programs for specific denominations and denominational groups.
3. Clarify the role of faith institutions in prevention programming among all organizations involved in the response to HIV/AIDS.

Recommendations for technical support include:

1. Support efforts by clergy to educate other clergy about HIV/AIDS.
2. Support the creation and development of organizations that assist African-American religious communities in responding to HIV/AIDS.
3. Assist African-American churches and mosques in forming partnerships with one another, with local health departments, AIDS services organizations, and community-based organizations to provide HIV/AIDS programming.
4. Disseminate information about "best practices" in faith-based prevention programming, including programming for church members, and for the larger community, such as street outreach.
5. Provide training in data-driven programming. Educate faith institutions about selecting prevention strategies that respond to documented needs. Encourage investment in program evaluation by helping faith institutions understand how evaluation can improve programs and maximize their impact.
6. Celebrate successes and seek continuous improvement in HIV prevention programming.

While the study revealed some of the difficulties African-American religious institutions face in addressing HIV/AIDS, study findings also reinforce the sense that churches and mosques have considerable potential to make a difference. In the words of a recent report from the Urban League, "The black churches were the birthplace of black schools and of all agencies which sought to promote the intelligence of the masses; and even today, no agency serves to disseminate news or information so quickly and effectively among blacks as the church. Today, when African Americans are so disproportionately impacted by HIV disease, the African-American church must once again rise and provide the catalyst for change necessary for the prevention of HIV infection."[1]

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[1] National Urban League, Inc. *State of Black America*. New York: NUL, Inc., 1995.